

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL					d. STREET ADDRESS 524 FRANKLIN				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Elmer BERNARD			Middle Anderson			Last			4. DATE OF DEATH Month JULY Day 15 Year 1966				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 6, 1906		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRONICS ENGINEER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) NEW YORK			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME BERNARD ANDERSON					14. MOTHER'S MAIDEN NAME EMELY PETERSON								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 064-07-6207		17. INFORMANT Address MARIE A. ANDERSON SAME AS # 2 ABOVE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct 4201 DUE TO (b) Hypertensive cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) disease										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from March, 1966 to June 15, 1966 that (I) (we) last saw the deceased alive on June 15, 1966 and that death occurred at 12:55 P.M. from the causes and on the date stated above.													
22a. SIGNATURE J. C. Roa M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) J. C. Roa M.D.						22d. ADDRESS LEXINGTON PARK, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BY CREMATION			23b. DATE THEREOF JULY 19, 1966		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL			23d. LOCATION (City, town or county) (State) SUITLAND, MARYLAND					
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND						25a. REC'D BY REGISTRAR JUL 18 1966			25b. REGISTRAR'S SIGNATURE J. Charles Judge				

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY ST. MARY'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b 12 HRS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X AVENUE d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOHN BENJAMIN BROWN			4. DATE OF DEATH JULY 19 1966						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 13, 1880		9. AGE (In years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK BROWN					14. MOTHER'S MAIDEN NAME GEORGIANA HERBERT				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT MRS FRANCES WOODALL Address AVENUE, MARYLAND				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension & Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1956 to July 19, 1966 , that (I) (we) last saw the deceased alive on July 19, 1966 , and that death occurred at 7:00 PM , from the causes and on the date stated above.									
22a. SIGNATURE Charles Greenwell								22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CHARLES GREENWELL M.D.					22d. ADDRESS LEONARDTOWN, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 23, 1966		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY			23d. LOCATION (City, town or county) (State) BUSHWOOD, MARYLAND		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY ADDRESS LEONARDTOWN, MARYLAND					25a. REC'D BY REGISTRAR JUL 26 1966 25b. REGISTRAR'S SIGNATURE Charles Judge				

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

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1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - COMPTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARYS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALBERT Middle L. Last EMBREY JR.		4. DATE OF DEATH Month JULY Day 24 Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/1908
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 58 Days 18 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DEPUTY POLICE CHIEF		10b. KIND OF BUSINESS OR INDUSTRY D. C. POLICE DEPT.	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALBERT L. EMBREY SR.		14. MOTHER'S MAIDEN NAME ELLA MARY FREEMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 577 14 3213	
17. INFORMANT MRS. ELINORA EMBREY - WASHINGTON, D.C.		Address 4000 MASS. AVE. N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic HD (c) 2 yrs		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> 7/24/66			
ACTUAL SIGNATURE Wm. D. Boyd M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WM. D. BOYD M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) LEONARDTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/27/66	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND
24. FUNERAL DIRECTOR JOHN M. WELCH - LEONARDTOWN, MD.		25a. REC'D BY REGISTRAR DATE JUL 26 1966	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Patuxent River, Md.</u> c. LENGTH OF STAY IN It <u>4 mos. 17 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Station Hospital, USNAS Patuxent Riv.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u> d. STREET ADDRESS <u>419 Chinlee Dr.</u>			
3. NAME OF DECEASED (Type or print) <u>Laura Marie Gibson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>19 66</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>March 8, 1966</u>	9. AGE (In years last birthday) <u>4</u> yrs. IF UNDER 1 YEAR Months <u>4</u> Days <u>17</u> IF UNDER 24 HRS. Hours <u>17</u> Min. <u>✓</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>St. Mary's, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Everett Gerard Gibson</u>			14. MOTHER'S MAIDEN NAME <u>Catherine Elizabeth Regan</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Everett G. Gibson</u> Address <u>419 Chinlee Dr.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Increased intracranial pressure</u> DUE TO (c) <u>Hydrocephalous</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Meningomyelocele</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>July 19, 1966</u> to <u>July 22, 1966</u> , that (I) (we) last saw the deceased alive on <u>July 22, 1966</u> , and that death occurred at <u>1200 am</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>J. W. Wengert</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>July 22, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. W. Wengert, LCDR MC USN</u>		22d. ADDRESS <u>Station Hospital USNAS Patuxent Riv.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JULY 25, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HOLY FACE CEMETERY</u>	23d. LOCATION (City, town or county) <u>GREAT MILLS, MARYLAND</u> (State)				
24 FUNERAL DIRECTOR'S SIGNATURE <u>W. CLARKE MATTINGLEY</u>			ADDRESS <u>LEONARDTOWN, MARYLAND</u>				
25a. REC'D BY REGISTRAR <u>JUL 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					

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UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

10475

1. PLACE OF DEATH a. COUNTY ST. MARY'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lexington Park d. STREET ADDRESS Route 2 Box 88 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOYCE Middle REBECCA Last GRAY			4. DATE OF DEATH Month JULY Day 4 Year 19 66				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH July 2 1966		9. AGE (in years last birthday) — yrs. 2		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME MATHEW ETHELBERG GRAY			14. MOTHER'S MAIDEN NAME BARBARA JEAN CLARK				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother Address Lexington Park, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 7635 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Premature birth. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 12 hours							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July 2, 1966 , to July 4, 1966 , that (I) (we) last saw the deceased alive on July 3, 1966 , and that death occurred at 2 A M, from the causes and on the date stated above.							
22a. SIGNATURE PJ Bean		22b. DATE SIGNED July 4/66					
22c. PHYSICIAN'S NAME (Type) Philip J. Bean M.D.		22d. ADDRESS Great Mills, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/6/66		23c. NAME OF CEMETERY OR CREMATORY OUR LADY'S CHAPEL			
23d. LOCATION (City, town or county) MEDLEY'S NECK MD.							
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR LEONARDTOWN, MD.		25b. REGISTRAR'S SIGNATURE J. Charles Judge			
25c. DATE JUL 11 1966							

FOR STATE
HEALTH DEPT.

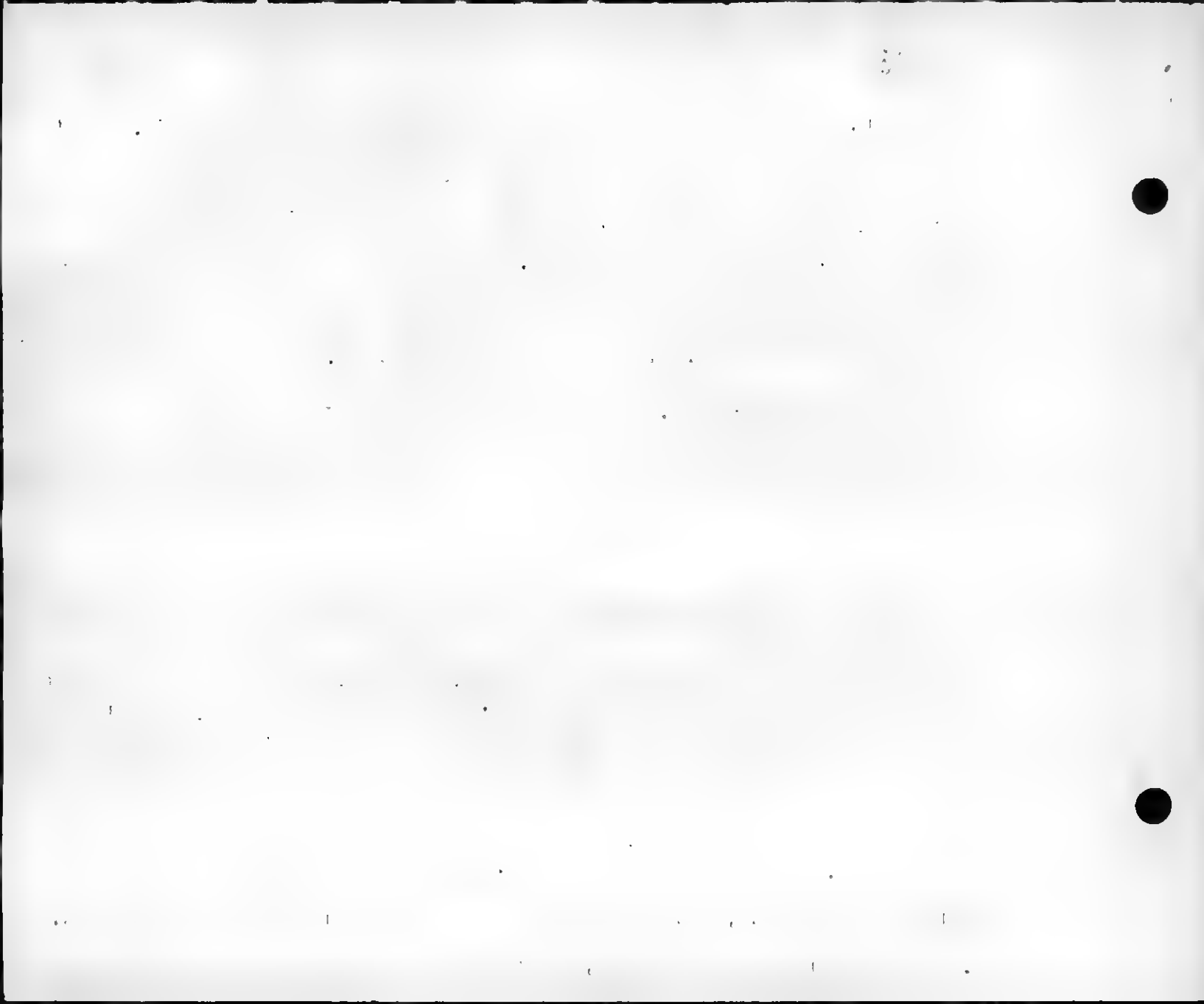
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dameron</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>U. S. Naval Air Station,</u>		d. STREET ADDRESS <u>Patuxent River, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Henry HEDETNIEMI, Jr.</u>		4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1966</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>15 OCT 46</u>	
9. AGE (In years last birthday) <u>19</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Airman</u>		11. BIRTHPLACE (State or foreign country) <u>Pittston, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Henry HEDETNIEMI, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Jean (n) NEFF</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>165-3844-12</u>		17. INFORMANT <u>Enlisted Personnel Record</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Injuries</u> DUE TO (b) <u>Automobile Accident</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>6167</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Passenger in a vehicle that was parked, and was struck</u>		20c. TIME OF INJURY Month, Day, Year Hour <u>10:35</u> p.m. <u>July 13 1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>St. Mary's</u> (County) <u>Dameron, Maryland</u> (State) <u>St. Mary's</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>14 JUL 66</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JULY 16, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PITTSSTON, PENNA.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>W. CLARKE MATTINGLEY</u>		25a. REC'D BY REGISTRAR <u>JUL 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>		25c. ADDRESS <u>LEONARDTOWN, MARYLAND</u>		25d. ADDRESS (Street, city, town, or county)		25e. ADDRESS (Street, city, town, or county)	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

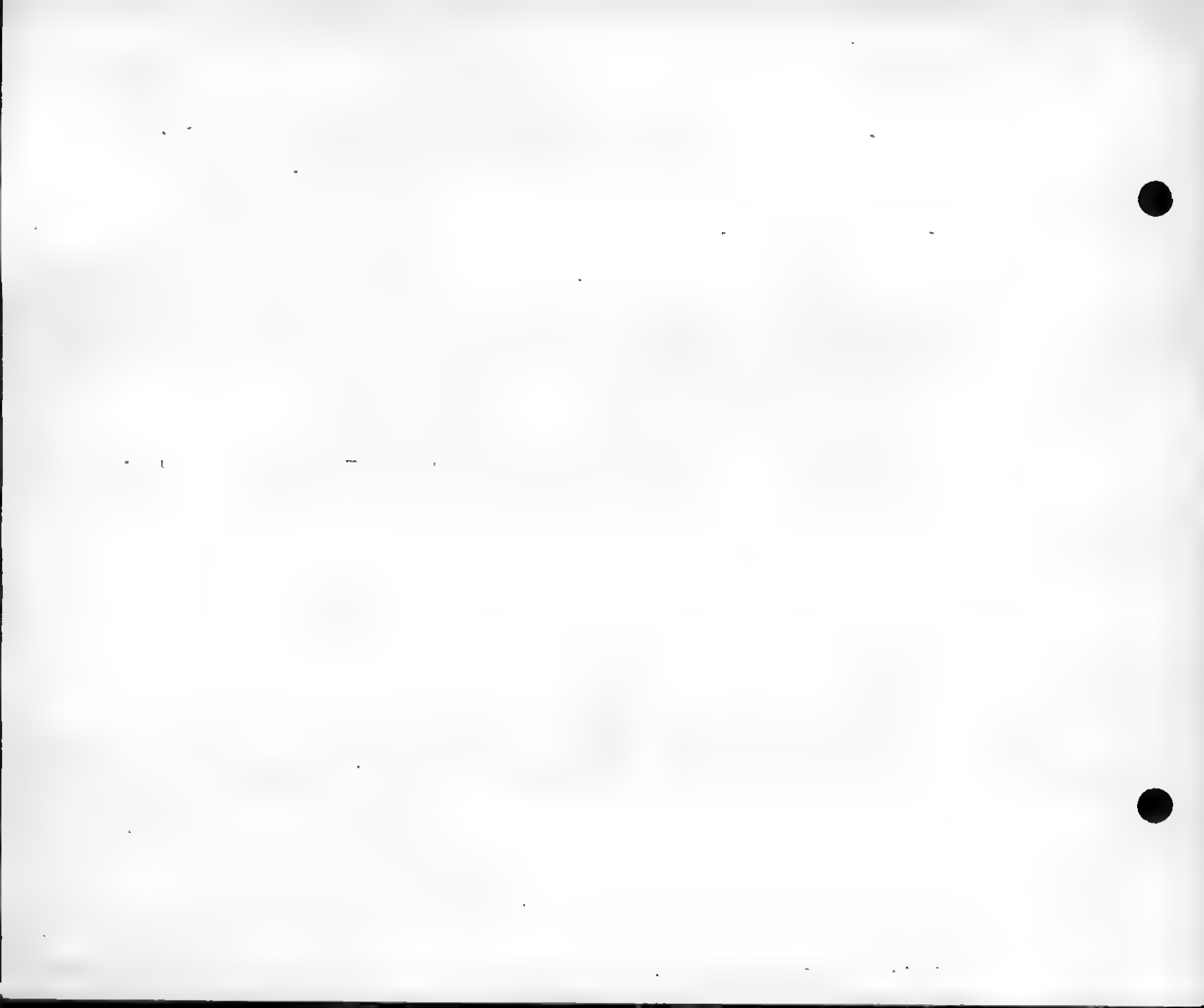
10384

10477

1 PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARYS NURSING HOME		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First Middle Last SARAH ELIZABETH HERBERT		4 DATE OF DEATH Month Day Year JULY 26 19 66	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/17/1882
9 AGE (In years last birthday) 83 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11b KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11c BIRTHPLACE (County & State, or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WM. JOSEPH DAVIS		14. MOTHER'S MAIDEN NAME MARY DAVIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 720 16 5342	
17. INFORMANT HARRY C. DAVIS - MECHANICSVILLE, MD.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac decompensation 0021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Obstructive airway disease DUE TO (c) Pulmonary tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 2 d	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Emphysema		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 78 , to July , 19 66 , that (I) (we) last saw the deceased alive on July 25 19 66 and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 7/27/66	
22c. PHYSICIAN'S NAME (Type) JOHN M. WELCH		22d. ADDRESS MECHANICSVILLE, MARYLAND	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/28/66	23c. NAME OF CEMETERY OR CREMATORY ALL FAITH CEMETERY	23d. LOCATION (City or Town) (County) (State) CHARLOTTE HALL, MARYLAND
24. FUNERAL DIRECTOR JOHN M. WELCH - LEONARDTOWN, MARYLAND		25a. RECD BY REGISTRAR DATE AUG 1 1966	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

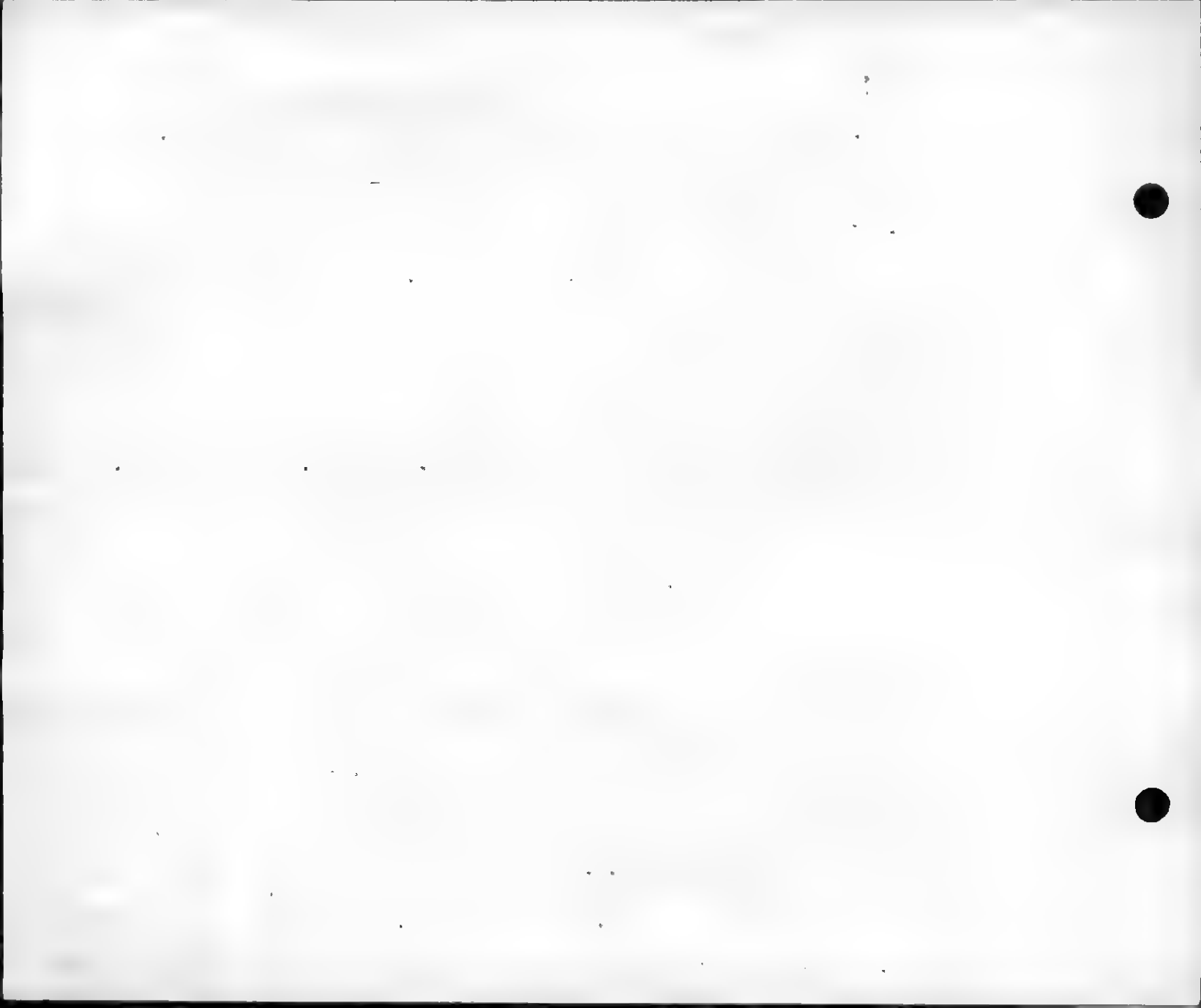
10485

10478

1 PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution before admission) a. STATE MARYLAND b. COUNTY ST. MARYS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. LENGTH OF STAY IN To			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARYS HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First HERMAN Middle WALTER Last HEWITT SR.				4 DATE OF DEATH Month JULY Day 23 Year 19 66			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2/1/1882	9 AGE (in years last birthday) 84 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY FARM		11 BIRTHPLACE (County & State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME JOHN HEWITT				14 MOTHER'S MAIDEN NAME MARY GRAVES			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 220 34 7926		17 INFORMANT Address HERMAN W. HEWITT JR. VALLEY LEE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute dilatation of Heart 143X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Cardio-Vascular disease DUE TO (c) Semility + Hypertension + Diabetic							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 1/15 , 19 57 , to July 23 , 19 66 that (I) (we) last saw the deceased alive on July 23 , 19 66 , and that death occurred at 11:30 AM , from causes and on the date stated above.							
22a. SIGNATURE Charles Greenwell M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/25/66	
22c. PHYSICIAN'S NAME (Type) CHARLES GREENWELL M.D.				22d. ADDRESS LEONARDTOWN, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/26/66		23c. NAME OF CEMETERY OR CREMATORY ST. GEORGE'S CEMETERY		23d. LOCATION (City or Town) (County) (State) VALLEY LEE, MARYLAND	
24. FUNERAL DIRECTOR John M. Welch JOHN M. WELCH - LEONARDTOWN, MARYLAND				25a. REC'D BY REGISTRAR DATE JUL 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10486

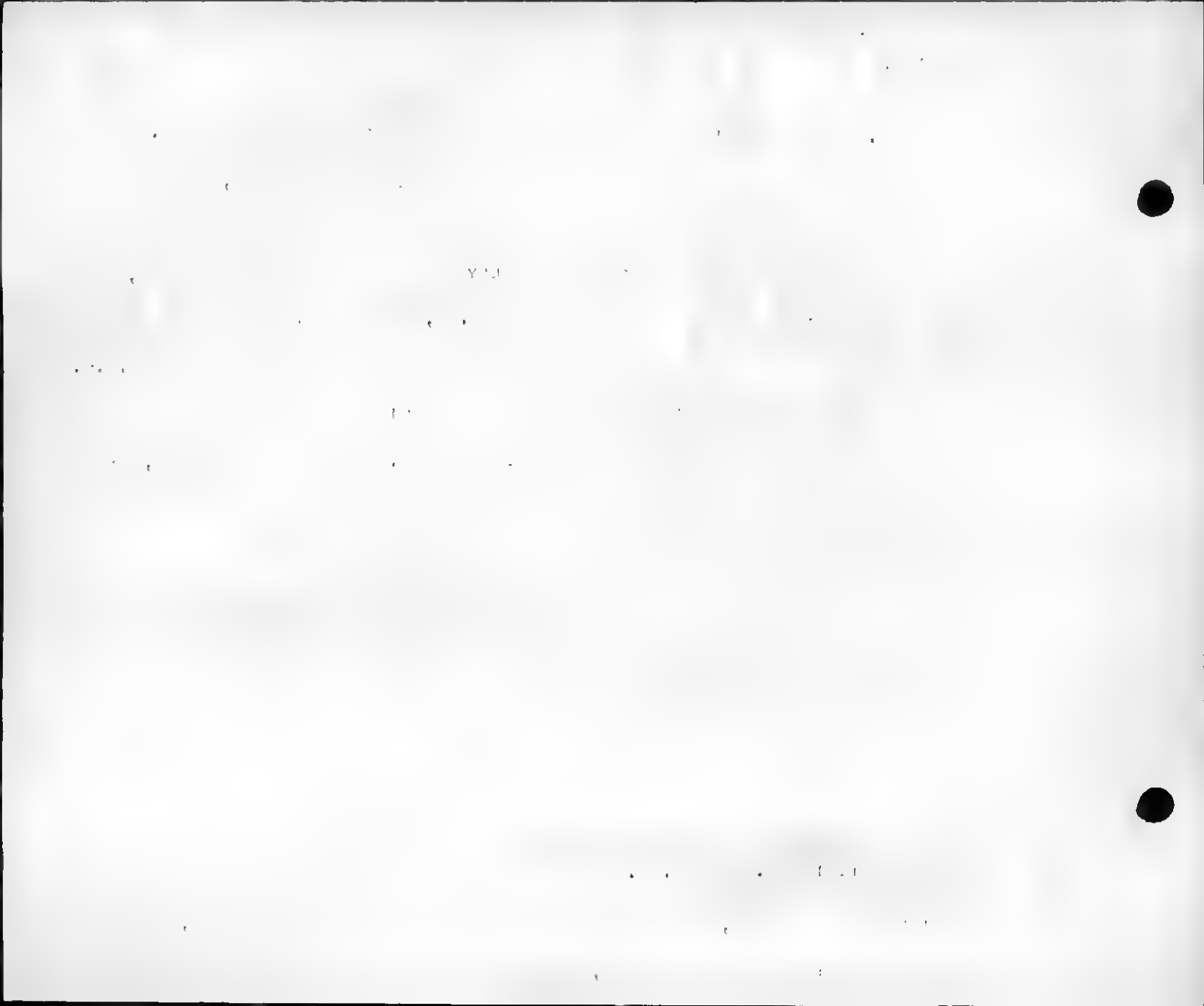
10479

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.

1 PLACE OF DEATH a COUNTY ST. MARY'S XXXXXXX MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL LEONARDTOWN				c LENGTH OF STAY IN 1b RURAL LEONARDTOWN			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) THOMAS EDWARD HOLLY				4 DATE OF DEATH Month JULY Day 23 Year 1966			
5 SEX MALE	6 COLOR OR RACE COLORED	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH JAN. 26, 1948	9 AGE (In years last birthday) yrs 18	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME JOSEPH JACKSON HOLLY				14 MOTHER'S MAIDEN NAME ELIZABETH AGNES BROOKS			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 216-50-6818		17 INFORMANT ELIZABETH B. HOLLY Address LEONARDTOWN, MARYLAND			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Enter Chronic Disease 8164 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture left femur						INTERVAL BETWEEN ONSET AND DEATH 2-3 weeks	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Head on car accident					
20c TIME OF INJURY Month, Day, Year Hour am 7-23 1966		20d INJURY OCCURRED While <input type="checkbox"/> at work hal While <input checked="" type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) St ROUTE 25		20f (City or town) (County) (State) Lanester ST Mary's	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William D. Boyd M.D. EXAMINER'S NAME (Type) WILLIAM D. BOYD M.D.				22. DATE SIGNED 7/27/66			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF JULY 26, 1966		23c NAME OF CEMETERY OR CREMATORY OUR LADY'S CHAPEL		23d LOCATION (City or town) (County) (State) MEDLEY'S NECK, MARYLAND	
24 FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND				25a REC'D BY REGISTRAR DATE JUL 27 1966		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

22

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY ST. MARY'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b 11 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL MECHANICSVILLE d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) SUSIE First HOLT Middle HOLT Last			4. DATE OF DEATH Month JULY Day 10 Year 1966						
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 5, 1889		9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? ? ?					14. MOTHER'S MAIDEN NAME ? ? ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MARY C. HOLT Address MECHANICSVILLE, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Thrombosis (b) ASCVD (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 4 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 10, 1966</u> to <u>JULY 10, 1966</u>, that (I) (we) last saw the deceased alive on <u>19</u>, and that death occurred at <u>11</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>[Signature]</i>								22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS MECHANICSVILLE, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 13, 1966		23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH'S CEMETERY		23d. LOCATION (City, town or county) (State) MORGANZA, MARYLAND			
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY				ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR JUL 14 1966		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

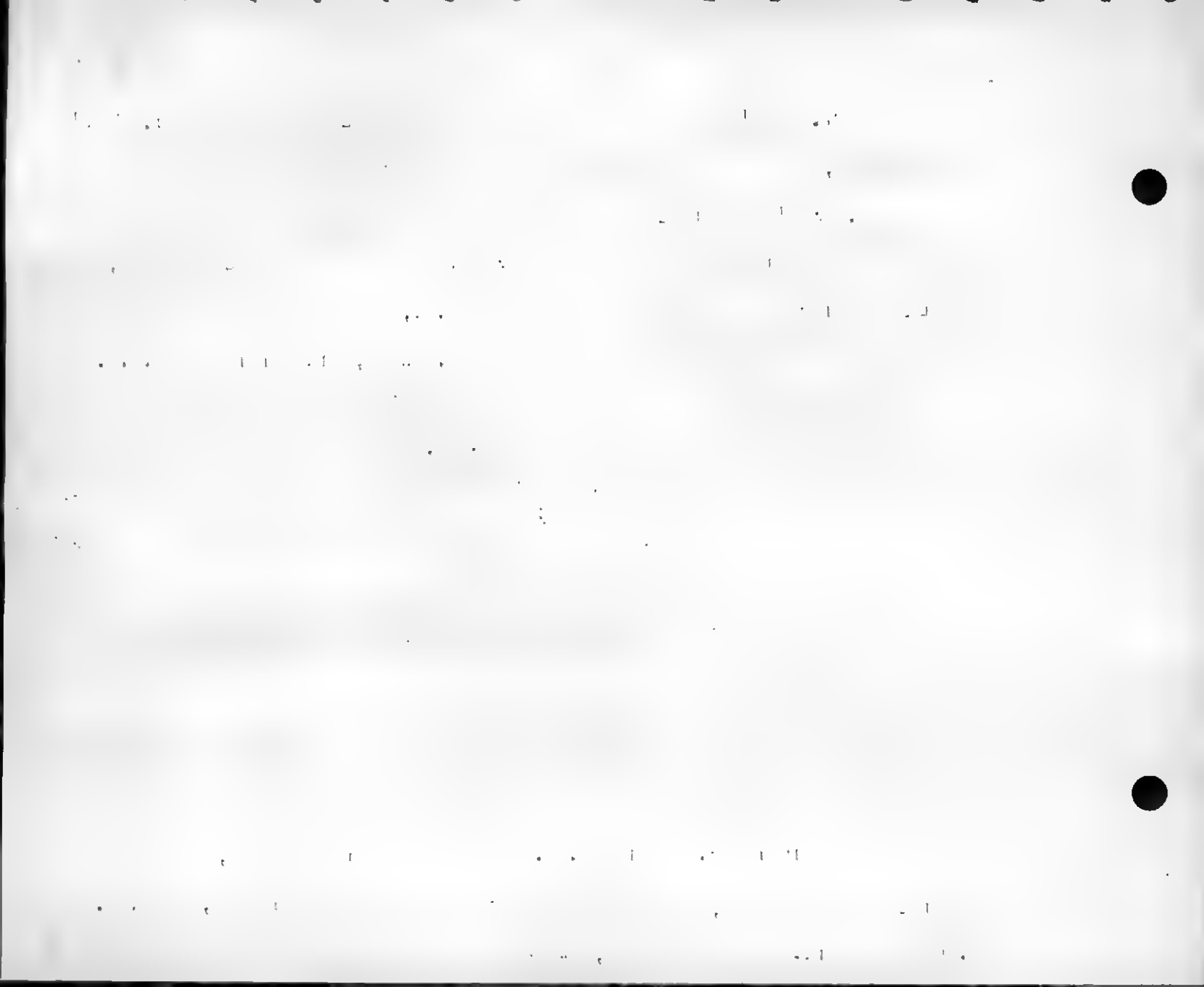


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN,					c. LENGTH OF STAY IN ID 8 DAYS				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL					d. STREET ADDRESS Rt 1 Box 176				
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle ANN Last LEFORT					4. DATE OF DEATH Month JULY Day 20 Year 19 66				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 1, 1880		9. AGE (In years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ST. LOUIS, MISSOURI			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN MATHEWS					14. MOTHER'S MAIDEN NAME MARGARET MULLEN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT JOHN V. LEFORT			Address SAME AS # 2 ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Arteriosclerotic Disease DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH 1 Year - 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post. Operative Repair of Diaphragmatic Hernia									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 14, 1966 to July 20, 1966 that (I) was last saw the deceased alive on July 14, 1966 , and that death occurred at 8:20 A.M. from the causes and on the date stated above.									
22a. SIGNATURE W. H. Patrick					22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) WILLIAM H. PATRICK M. D.	
22d. ADDRESS LEXINGTON PARK, MARYLAND					22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF JULY 22, 1966		23c. NAME OF CEMETERY OR CREMATORY GLEENWOOD CEMETERY			23d. LOCATION (City, town or county) (State) WASHINGTON, D. C.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND					25a. REC'D BY REGISTRAR JUL 26 1966				
25b. REGISTRAR'S SIGNATURE Charles Judge									

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil, item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Item #12 Film#G3018/17 MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items #11, 12 Film G370 7/14/66 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Items #3 & 11 Film #3319 7/27/66													
1 PLACE OF DEATH a COUNTY St. Mary's MARYLAND						2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE D.C. b COUNTY ✓							
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bushwood				c LENGTH OF STAY IN lb		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				d STREET ADDRESS 2715 - 17th Street, N.E.			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Lon-view Beach						b RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) BRANTLEY Lee LINDER Jr.						4 DATE OF DEATH July 3 19 66							
5 SEX Male		6 COLOR OR RACE Colored		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8 DATE OF BIRTH April 24, 1939		9 AGE (In years last birthday) 27 yrs		IF UNDER 1 YEAR Months Days Hours Min			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Dist. Wash., D.C.				12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13 FATHER'S NAME						14 MOTHER'S MAIDEN NAME							
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes				16 SOCIAL SECURITY NO		17 INFORMANT Address							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Browning DUE TO Subluxation of neck with contusion of cervical spinal cord DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))												19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Dived into shallow water									
20c TIME OF INJURY Month, Day, Year 4:30 pm 7/3/ 19 66				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) Bathing beach		20f (City or town) (County) (State) Wicomico River St. Mary's Md.		21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher M.D.				EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				22. DATE SIGNED July 4, 1966					
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town) (County) (State) Arlington Va					
24 FUNERAL DIRECTOR W.H. Bacon 172 2 75 Ave						25a RECD BY REGISTRAR DATE JUL 11 1966		25b REGISTRAR'S SIGNATURE Charles Judge					



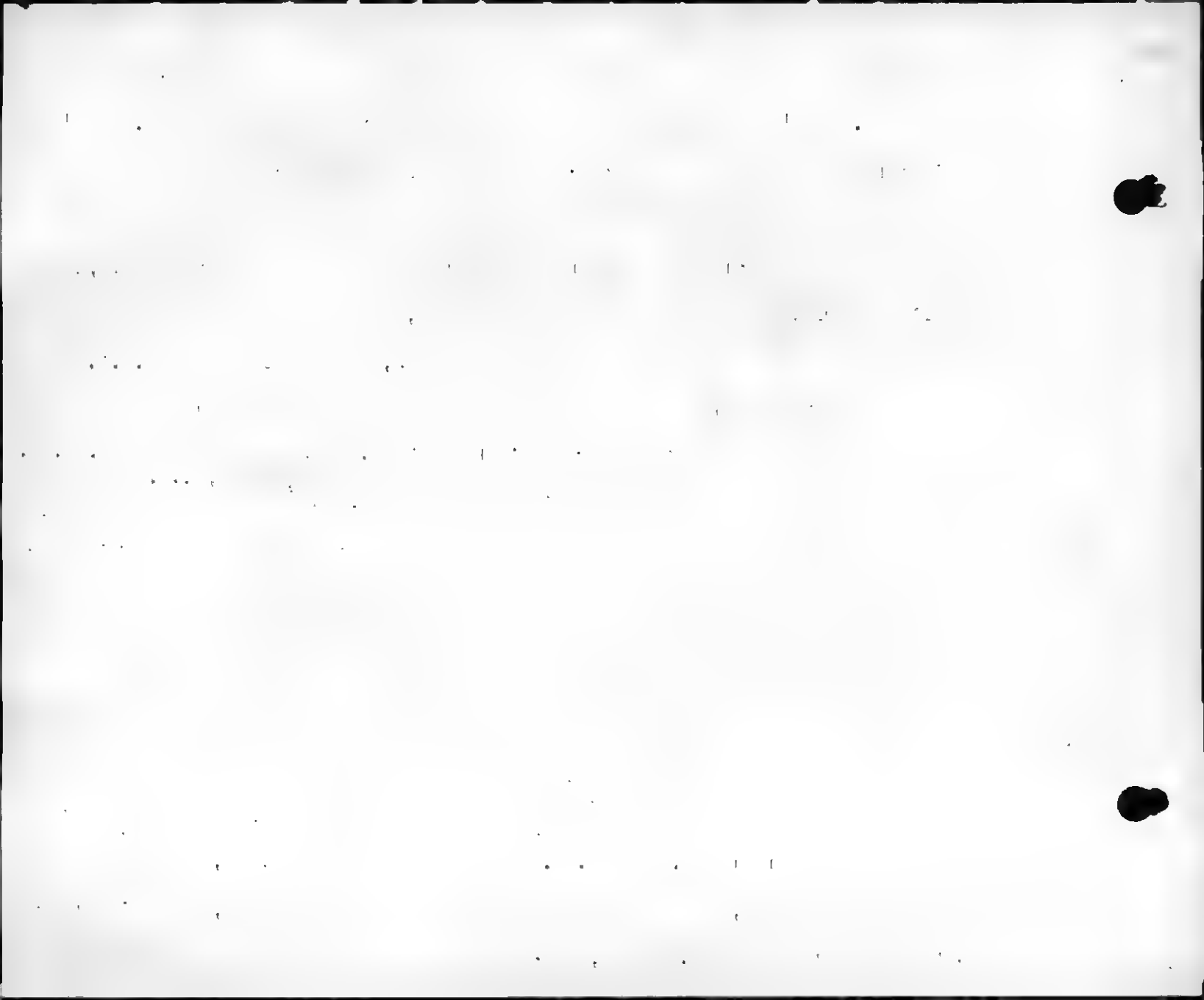
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										10483
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										10453
10480										10453
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHAPTICE			c. LENGTH OF STAY IN 1b 3 YEARS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL CHAPTICE			d. STREET ADDRESS 18-1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)										
3. NAME OF DECEASED (Type or print) First NELLIE Middle CURTIS Last NEALE			4. DATE OF DEATH Month JULY Day 18 Year 1966							
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 2, 1909		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 		IF UNDER 24 HRS. Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MADDOX, MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE CURTIS					14. MOTHER'S MAIDEN NAME MARY JANE HAWKINS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 213-38-0836		17. INFORMANT CHRISTOPHER C. NEALE Address 2800 WOODLEY RD. N. W.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 1700 DUE TO (b) arterio-sclerotic HD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 										INTERVAL BETWEEN ONSET AND DEATH 15 min 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from April 1962 to July 18, 1966 , that (I) (we) last saw the deceased alive on July 18, 1966 , and that death occurred at 11:33 M. from the causes and on the date stated above.										
22a. SIGNATURE W.D. Boyd M.D.					22b. DATE SIGNED 7/20/66					
22c. PHYSICIAN'S NAME (Type) WILLIAM D. BOYD M. D.					22d. ADDRESS LEONARDTOWN, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 21, 1966		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY		23d. LOCATION (City, town or county) (State) BUSHWOOD MARYLAND				
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY					ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR JUL 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

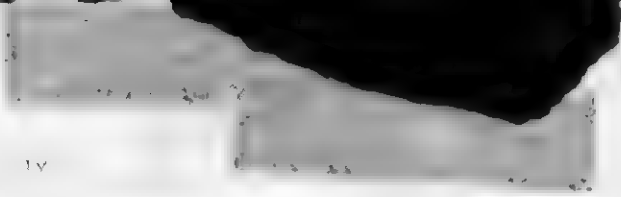


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

DIVISION OF STATISTICS		DEPARTMENT OF HEALTH		301 W. PRESTON STREET, BALTIMORE 1, MARYLAND	
10491		CERTIFICATE OF DEATH		10184	
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 2 HRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CALLAWAY	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle JOSEPH Last NORRIS			4. DATE OF DEATH Month JULY Day 31 Year 1966		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 1, 1907	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 15 Days 1 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) GREAT MILLS, Md.	
13. FATHER'S NAME WILLIAM L. NORRIS		14. MOTHER'S MAIDEN NAME LUCILLE DYER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-14-2906		17. INFORMANT MRS EDNA NORRIS CALLAWAY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse DUE TO (b) Myocardial Infarction DUE TO (c) Myocardial Infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH min. hr. hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (1) (this hospital) attended the deceased from Jan. 1965 to 8/31 1966 , that (1) (we) last saw the deceased alive on 7/15 1966 and that death occurred at 9:30 A.M. from the causes and on the date stated above.					
22a. SIGNATURE James P. Jarboe		22b. DATE SIGNED 8/4/66		22c. PHYSICIAN'S NAME (Type) JAMES P. JARBOE M. D.	
22d. ADDRESS GREAT MILLS, MARYLAND		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			
23b. DATE THEREOF AUG. 2, 1966		23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH'S CEMETERY		23d. LOCATION (City, town or county) (State) MORGANZA, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR DATE AUG 8 1966		25b. REGISTRAR'S SIGNATURE J. Clarke Judge	



14



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

10492

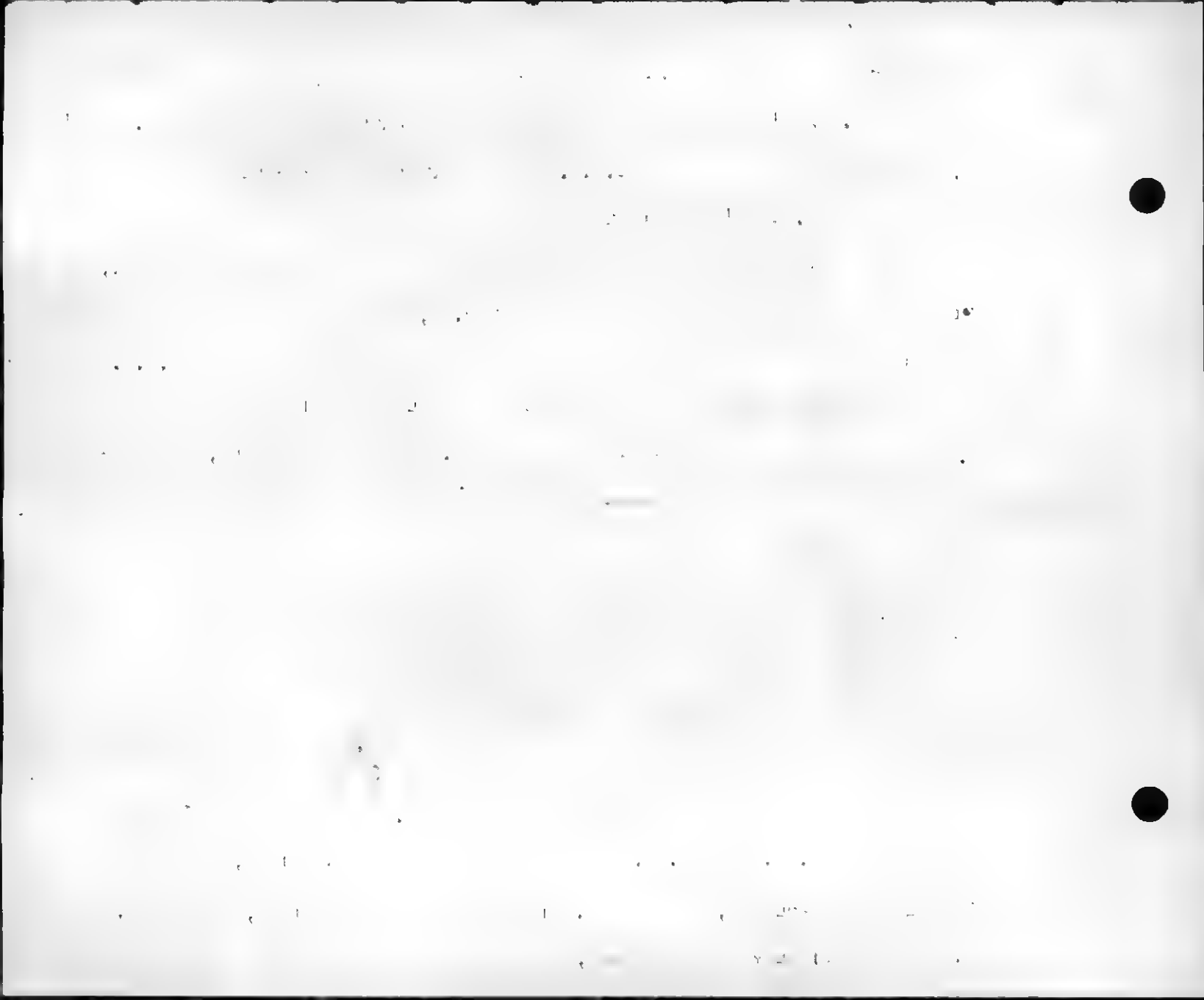
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10485

1. PLACE OF DEATH a. COUNTY ST. MARY'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL PARK HALL d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle EUGENE Last PEACOCK		4. DATE OF DEATH Month JULY Day 21 Year 1966	
5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 27, 1892 9. AGE (in years last birthday) 73 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOSEPH PEACOCK		14. MOTHER'S MAIDEN NAME ALICE CUNNINGHAM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220-34-4896 17. INFORMANT CORA E. PEACOCK Address PARK HALL, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arthritis, chronic and gout		INTERVAL BETWEEN ONSET AND DEATH 2 hours 49 years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April , 19 50 , to July 21 , 19 66 , that (I) (we) last saw the deceased alive on July 21 , 19 66 , and that death occurred at 8:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE P. J. BEAN M. D.		22b. DATE SIGNED 7/22/66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS GREAT MILLS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 23, 1966	
23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS		23d. LOCATION (City, town or county) (State) RIDGE, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR JUL 26 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

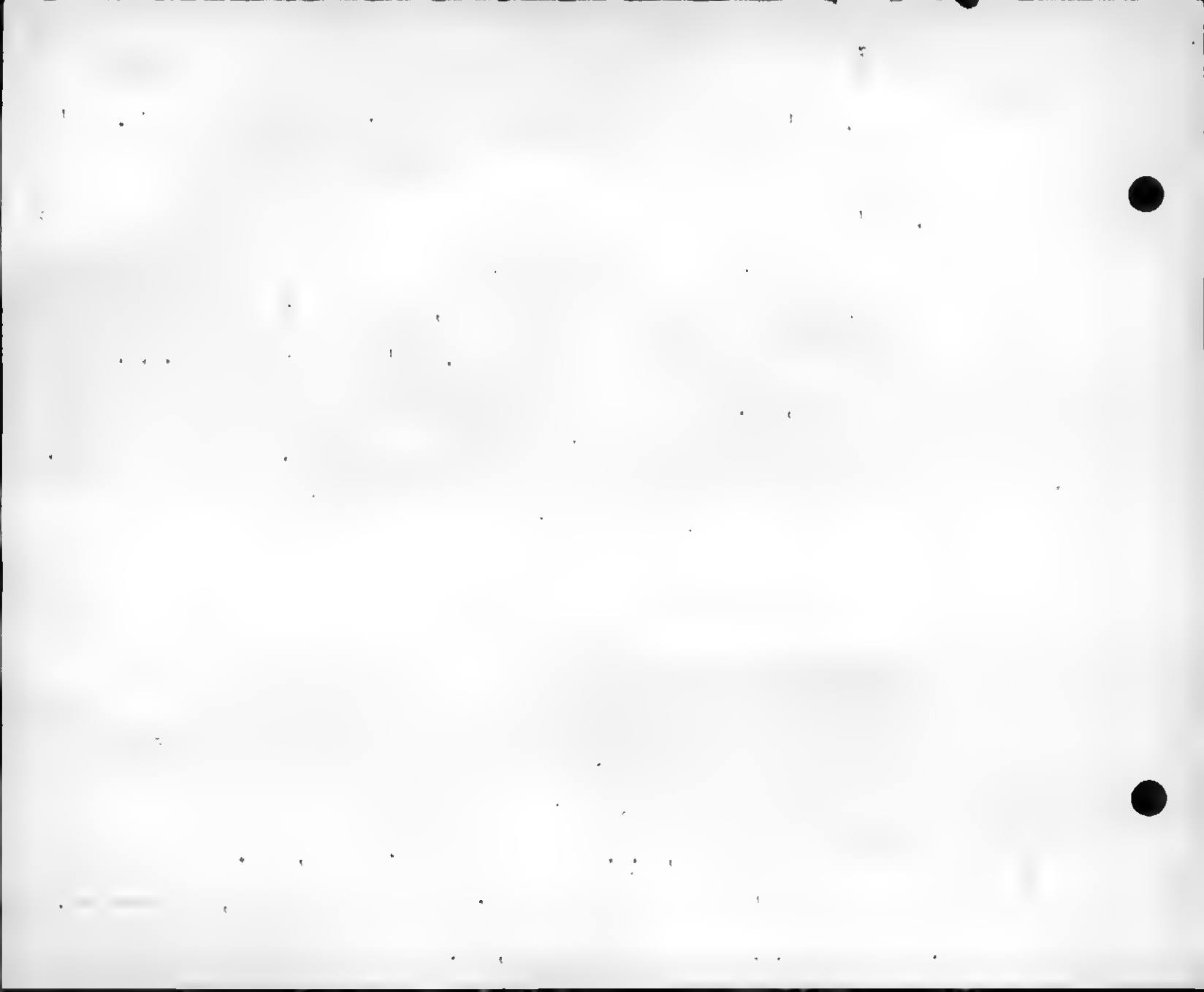


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
10487											
1. PLACE OF DEATH a. COUNTY ST. MARY'S						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS ANTHONY QUADE			First Middle Last			4. DATE OF DEATH Month 7 Day 6 Year 1966					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 24, 1964		9. AGE (in years last birthday) 2 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ST. MARY'S MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME DAVID ROY QUADE, JR.						14. MOTHER'S MAIDEN NAME PATRICIA ANN KNOTT					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT DAVID ROY QUADE JR.			Address LEONARDTOWN, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 0851 Bronchial Pneumonia DUE TO Measles Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7/6 , 19 66 , to 7/6 , 19 66 that (I) (we) last saw the deceased alive on 7/6 , 19 66 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE Charles Greenwell						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) CHARLES GREENWELL, M.D.						22d. ADDRESS LEONARDTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/8/66		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART			23d. LOCATION (City, town or county) (State) BUSHWOOD, MARYLAND.				
24. FUNERAL DIRECTOR W. CLARKE MATTINGEY						ADDRESS LEONARDTOWN, MD.			25a. REC'D BY REGISTRAR JUL 11 1966		
						25b. REGISTRAR'S SIGNATURE Charles Judge					



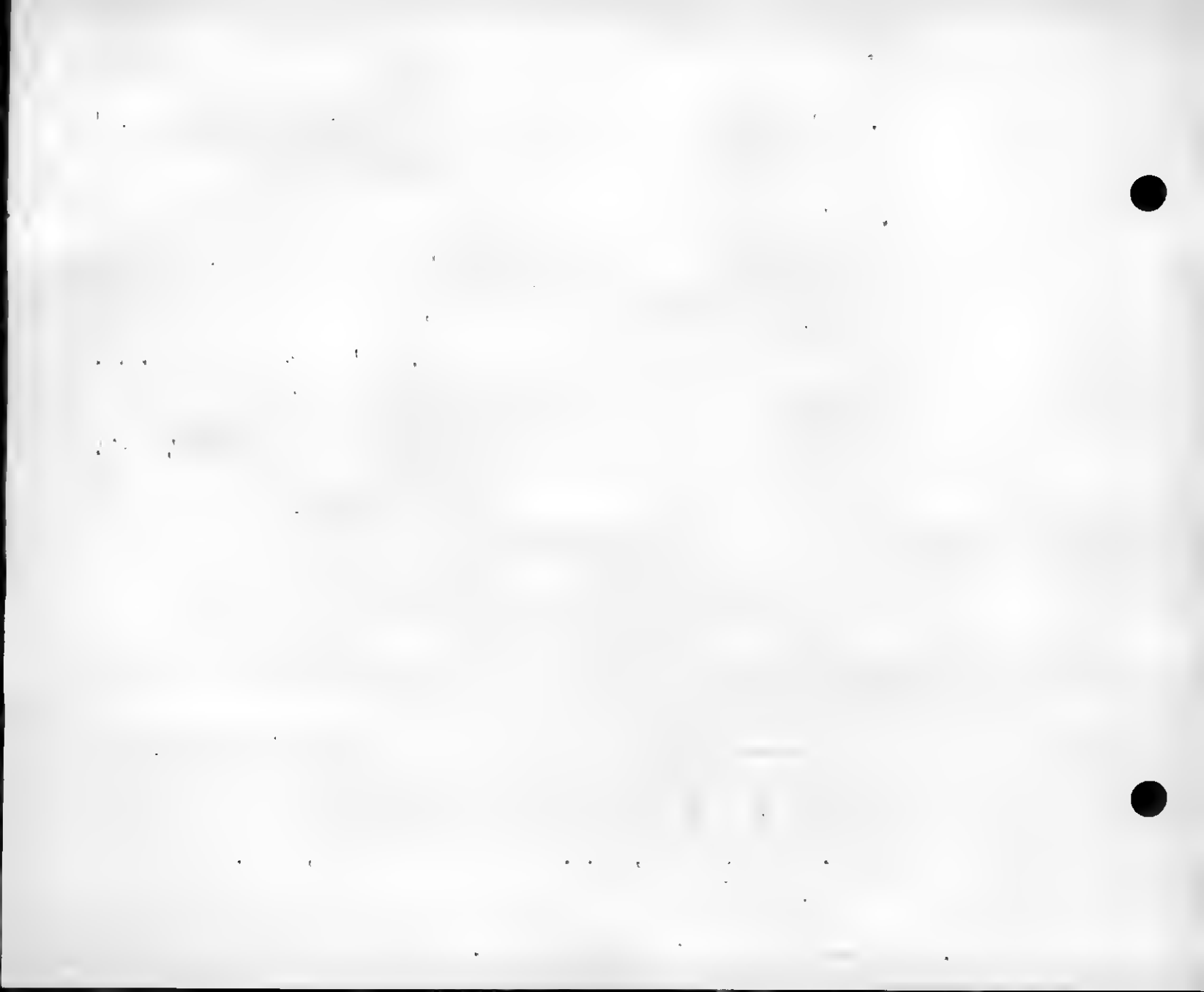
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VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>ST. MARY'S</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LEONARDTOWN</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ST. MARY'S</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ST. MARY'S</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CALLAWAY</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>PRICE</u> First Middle Last <u>BOY</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>6</u> Year <u>1966</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
5. SEX <u>M</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 5, 1966</u>		9. AGE (in years last birthday) yrs. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>ST. MARY'S MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN BARBER</u>					14. MOTHER'S MAIDEN NAME <u>AGNES MARIE PRICE</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>JOHN BARBER</u> Address <u>HOLLYWOOD, MD.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>7/5</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (1) (this hospital) attended the deceased from <u>7/5</u> , 19 <u>66</u> to <u>7/6</u> , 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>7/6</u> , 19 <u>66</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>J. Patrick Jarboe</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>J. PATRICK JARBOE, M.D.</u> 22d. ADDRESS <u>GREAT MILLS, MD.</u> 22b. DATE SIGNED <u>7/8/66</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THE REFD <u>7/9/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u> 23d. LOCATION (City, town or county) (State) <u>Leonardtown Md.</u> 24. FUNERAL DIRECTOR <u>W. CLARKE MATTINGLEY</u> ADDRESS <u>LEONARDTOWN, MD.</u> 25a. REC'D BY REGISTRAR <u>J. Charles Judge</u> 25b. REGISTRAR'S SIGNATURE DATE <u>JUL 14 1966</u>									

6-199



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

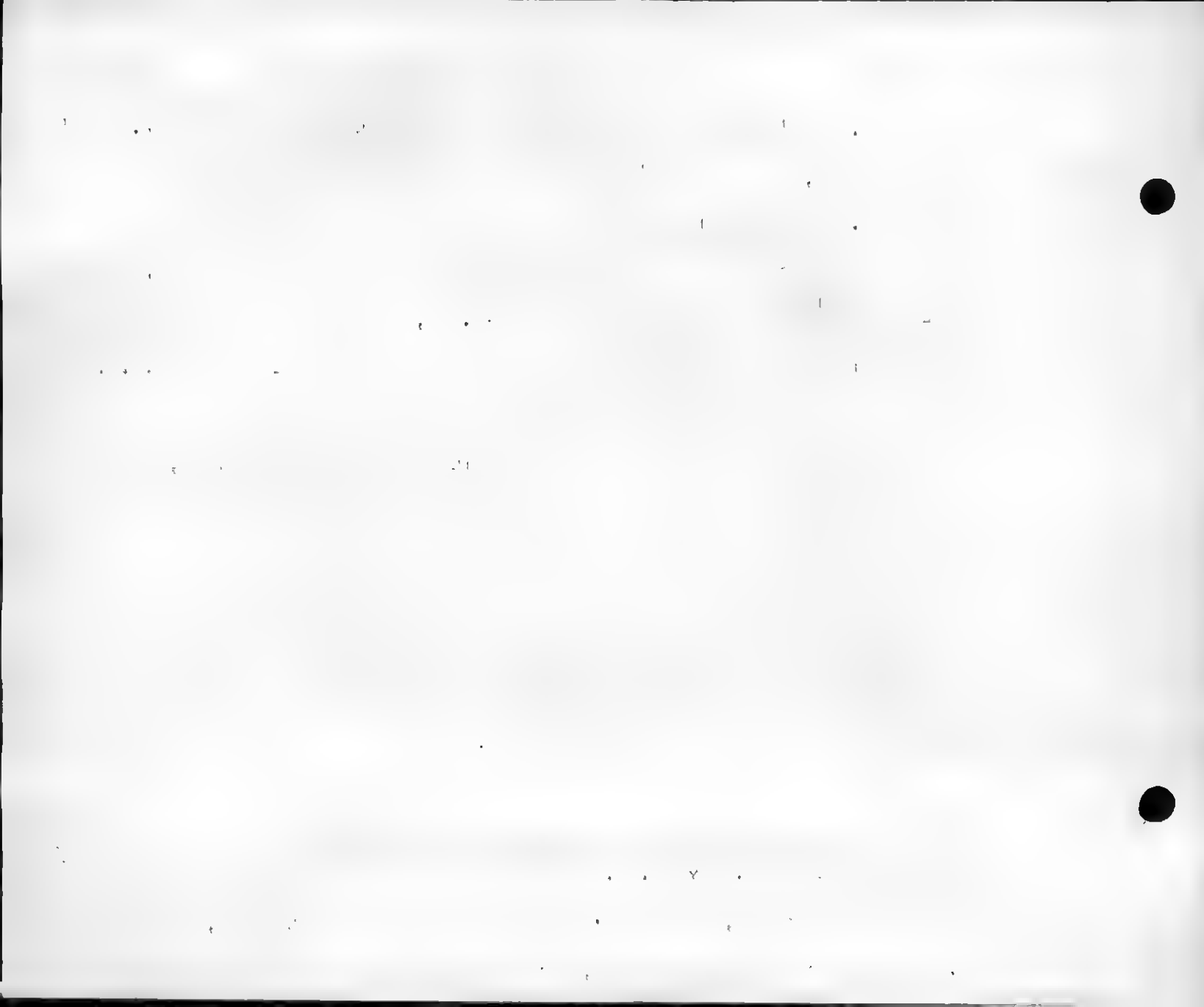
10488

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) LEONARDTOWN,		c. LENGTH OF STAY In 1b 18 DAYS c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) LEONARDTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		d. STREET ADDRESS LAWRENCE AVENUE	
3 NAME OF DECEASED (Type or print) First Middle Last BERTIE MARTHA READMOND		4 DATE OF DEATH Month Day Year JULY 23, 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH JAN. 10, 1882
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BROWN		14. MOTHER'S MAIDEN NAME MARGARET GATTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT MRS MILDRED KNOTT LEONARDTOWN, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured hip 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Struck on the head	
20c. TIME OF INJURY Month, Day, Year 6:00 p.m. 7-5-1966	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Leonardtown St. Mary's Md
21. I certify that I took charge of the removals described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE WILLIAM D. BOYD M. D.		22. DATE SIGNED 7/25/66	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JULY 25, 1966	23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS CEMETERY	23d. LOCATION (City or Town) (County) (State) HOLLYWOOD, MARYLAND
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR DATE JUL 27 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10496

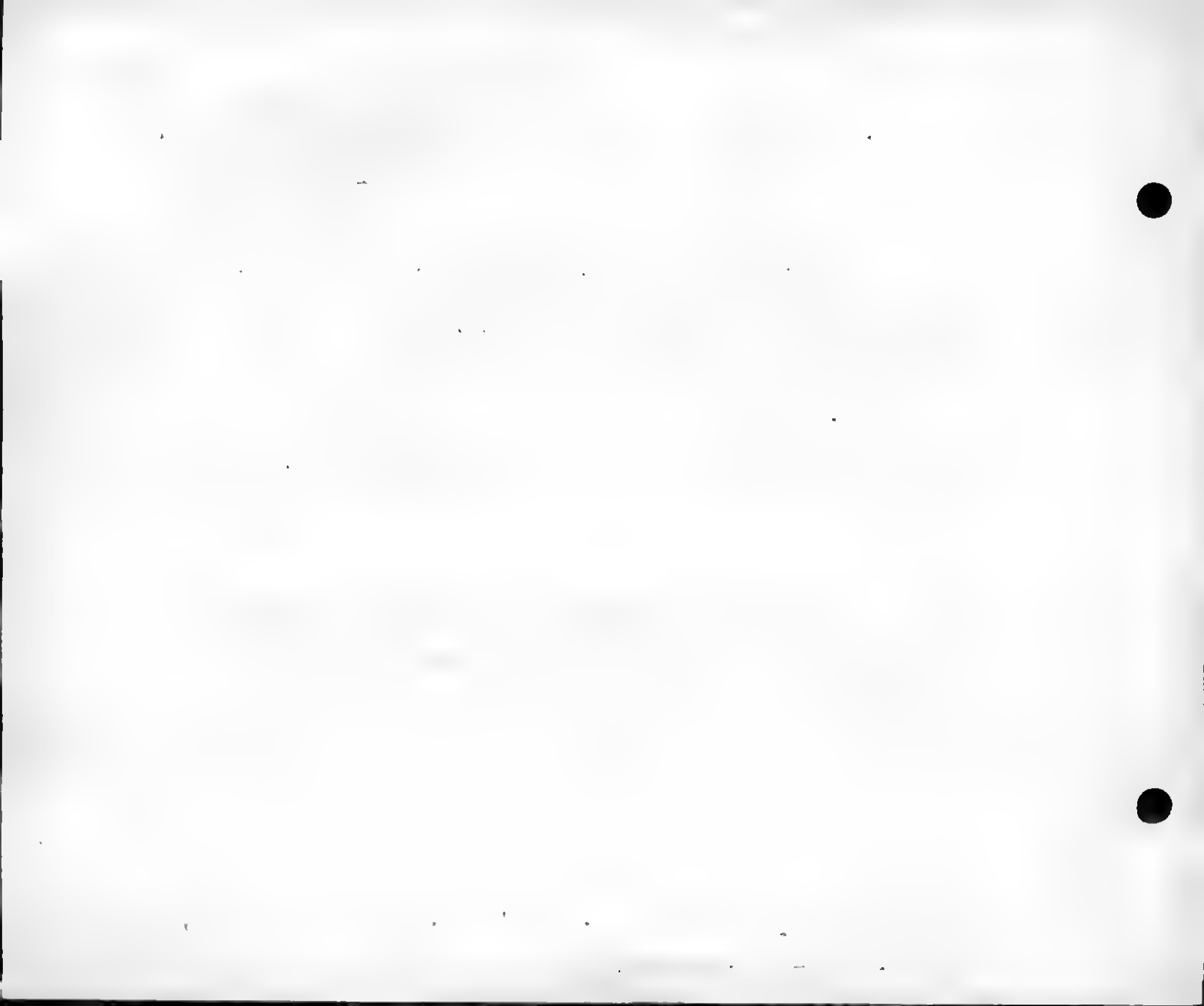
CERTIFICATE OF DEATH

10489

1 PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if instituton Res dence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakville (rural--near Mechanicsville)		c LENGTH OF STAY IN 1b RURAL - MECHANICSVILLE	
d NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address)		d STREET ADDRESS BOX 176	
3. NAME OF DECEASED (Type or print) First JENNIE Middle CORNELIA Last REED		4 DATE OF DEATH Month JULY Day 28 Year 19 66	
5 SEX FEMALE	6 COLOR OR RACE NEGRO	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/2/1885
9 AGE (In years last birthday) 81 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11 BIRTHPLACE (County & State, or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE W. THOMAS		14. MOTHER'S MAIDEN NAME ANNIE YOUNG	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 212 56 Q689	
17 INFORMANT JOSEPH REED - SAME AS #2		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerotic a disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Mar , 19 66 to July , 19 66 , that (I) (we) last saw the deceased alive on July 20 1966 , and that death occurred at 7:11 from causes and on the date stated above.			
22a. SIGNATURE J. Roy G. GUYTNER, M.D.		22b. DATE SIGNED 7/29/66	
22c. PHYSICIAN'S NAME (Type) J. ROY GUYTNER, M.D.		22d ADDRESS MECHANICSVILLE, MARYLAND	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 8/1/66	23c NAME OF CEMETERY OR CREMATORY ST. JOSEPH'S GEM.	23d LOCATION (City or Town) (County) (State) M ORGANZA, MARYLAND
24 FUNERAL DIRECTOR JOHN M. WELCH - LEONARDTOWN, MARYLAND		25a REC'D BY REGISTRAR AUG 2 1966	
25b. REGISTRAR'S SIGNATURE John M. Welch			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their place is to be removed, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in only event within 72 hours after death.

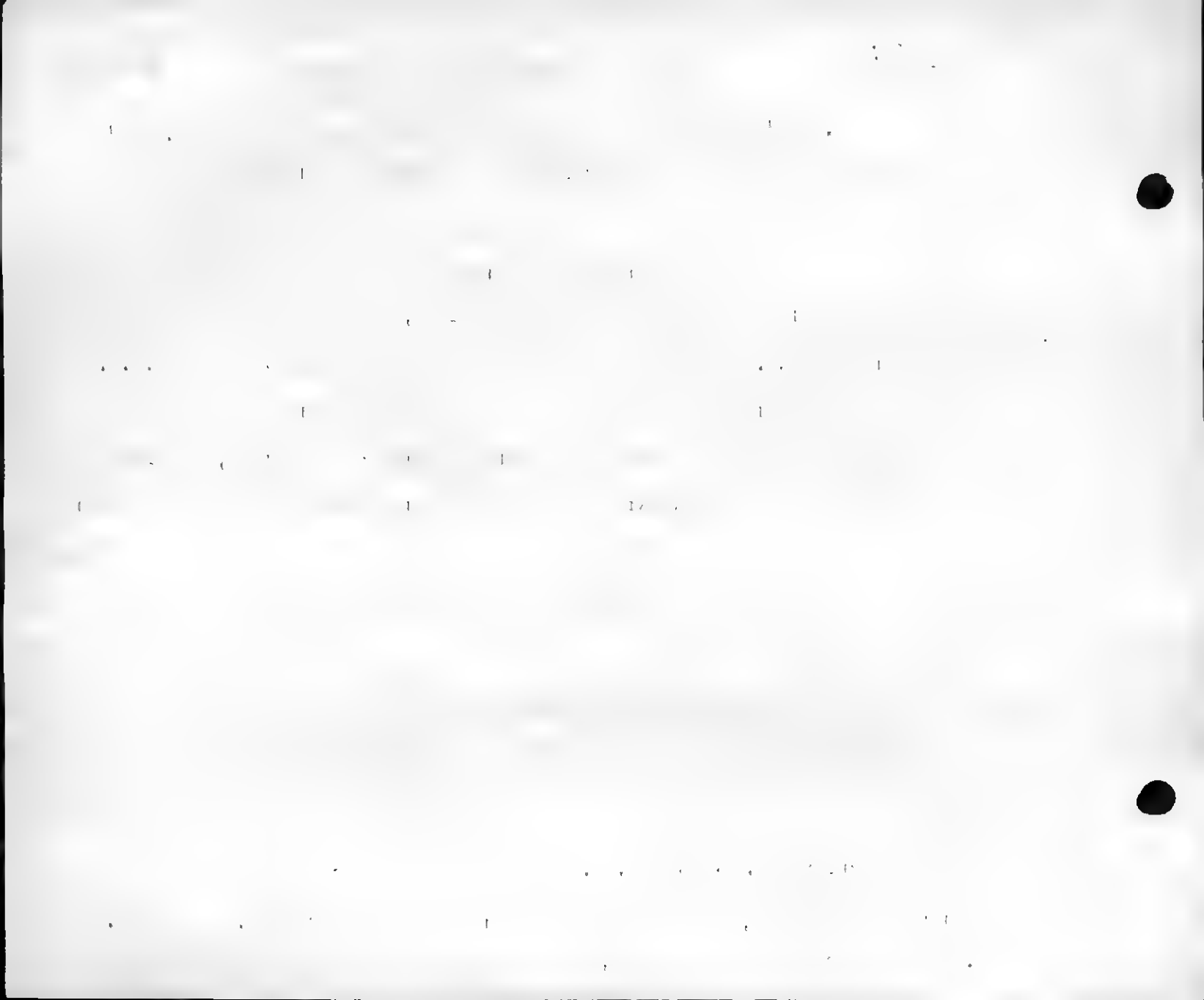
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. LENGTH OF STAY IN 1b 20 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last JOHNIE WILLIE SIMMONS		4. DATE OF DEATH Month Day Year JULY 5 19 66	
5. SEX MALE	6. COLOR OR RACE NEGRO ID	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 21, 1924
9. AGE (in years lost birthday) yrs 42		10. IF UNDER 1 YEAR Months Days Hours Min 42	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AS STATION ATTEND.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) GEORGIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SIMMONS		14. MOTHER'S MAIDEN NAME JANE MARTIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO 258-24 5825	
17. INFORMANT ANNIE LOU SIMMONS		Address RIDGE, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) XXXXXX O.D.E TO (b) Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 30 minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) No Injury	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W.H. Patrick EXAMINER'S NAME (Type) WILLIAM H. PATRICK M. D.		22. DATE SIGNED 7-6-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 8, 1966	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VA.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25. REGISTRAR'S SIGNATURE Charles Judge	
25a. REC'D BY REGISTRAR JUL 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10498

10491

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File copy and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and carry event within 72 hours after death.

1 PLACE OF DEATH a COUNTY ST. MARY'S MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE MARYLAND b COUNTY ST. MARY'S			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c LENGTH OF STAY IN 1b D.O.A.			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last ROBERT SYLVESTER SOMERVILLE				4 DATE OF DEATH Month Day Year JULY 1, 1966			
5 SEX MALE	6 COLOR OR RACE NEGRO	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH JAN. 3, 1961	9 AGE (in years last birthday) 5 y/s	10 UNDER 1 YEAR Months Days Hours Min.		11 UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME ROBERT SYLVESTER SOMERVILLE SR.				14 MOTHER'S MAIDEN NAME THERESA ANN CLARK			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO		17. INFORMANT Address MOTHER SAME AS # 2 ABOVE			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of chest. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 minutes.	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Accidentally shot by 3 year old sister					
20c TIME OF INJURY Month, Day, Year Hour p.m. 7-1 1966		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home		20f (City or town) (County) (State) Leonardtown Maryland	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W.H. Patrick		EXAMINER'S NAME (Type) WILLIAM H. PATRICK M. D.				22. DATE SIGNED 7-2-66	
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF JULY 4, 1966		23c NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY		23d LOCATION (City or Town) (County) (State) BUSHWOOD, MARYLAND	
24 FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND				25a REC'D BY REG STRAR DATE JUL 7 1966		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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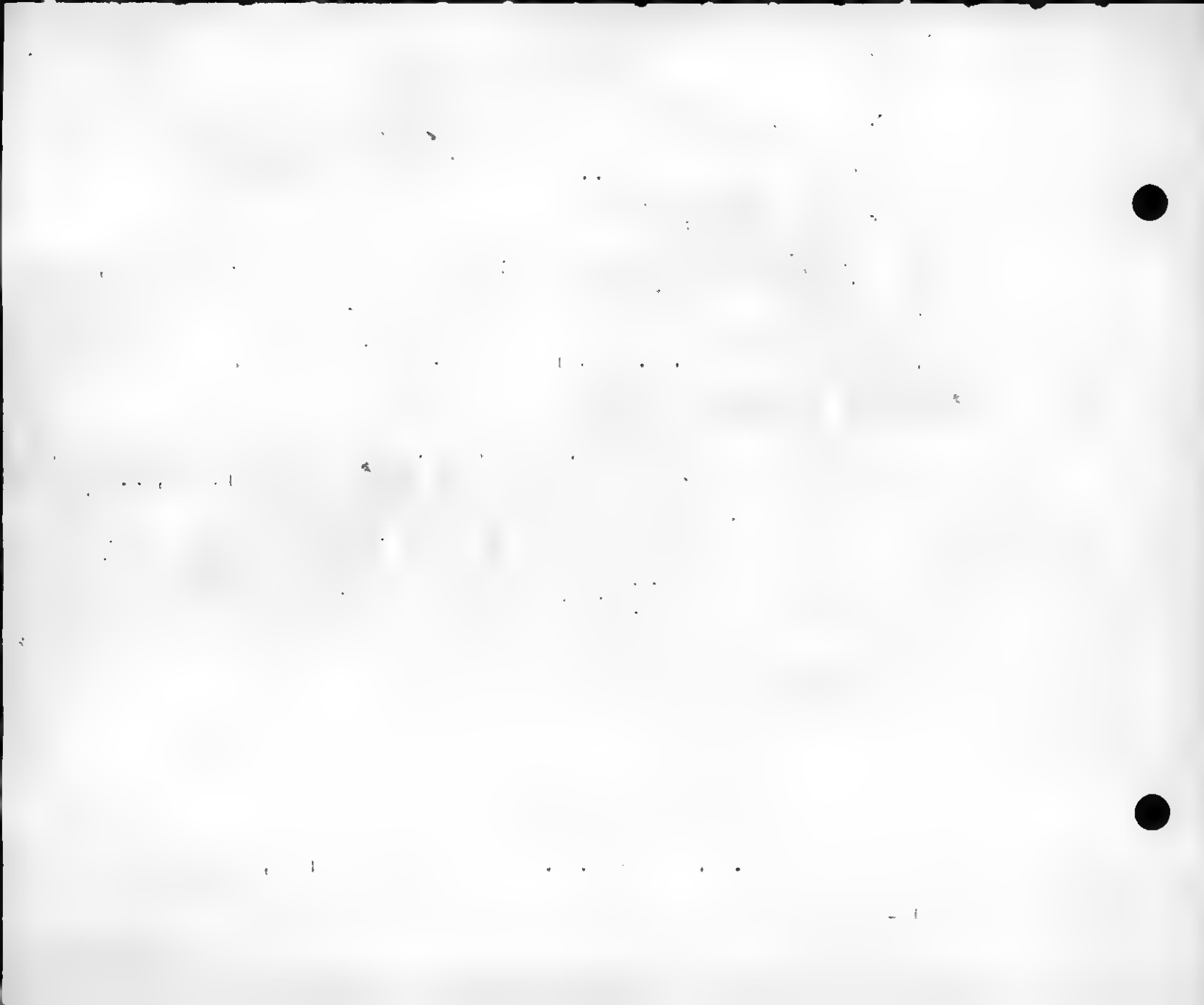
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10493 Item #4 10450
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ST. MARY'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN ID 1 HR. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY ST. MARY'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AVENUE, Md. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALFRED FRANCIS SPARSHOTT First Middle Last				4. DATE OF DEATH JULY 30 19 19 66 Month Day Year			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-7-04 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY D. C. TRANSIT		11. BIRTHPLACE (County & State, or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ALFRED SPARSHOTT (dec.)				14. MOTHER'S MAIDEN NAME STELLA HUTCHING			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 578-10-5831		17. INFORMANT EVELYN SPARSHOTT Address 1811 NORTH EDGEWOOD STREET			
18. CAUSE OF DEATH [Enter only one cause for line (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse DUE TO Ventricular Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Myocardial Infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 1 hr. hr. hr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 6/1/1966 to 7/30/1966 , that (I) (we) last saw the deceased alive on 7/30/1966 , and that death occurred at 12:35 P.M. from the causes and on the date stated above.							
22a. SIGNATURE James P. Jarboe				22b. DATE SIGNED 7/30/66			
22c. PHYSICIAN'S NAME (Type) JAMES P. JARBOE M. D.				22d. ADDRESS GREAT MILLS, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/2/1966		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION (City, town or county) (State) Falls Church, Va	
24. FUNERAL DIRECTOR IVES FUNERAL HOME By: J. B. Gray				ADDRESS Arlington, Va		25a. REC'D BY REGISTRAR DATE AUG 2 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



1
FOR STATE
HEALTH DEPT.

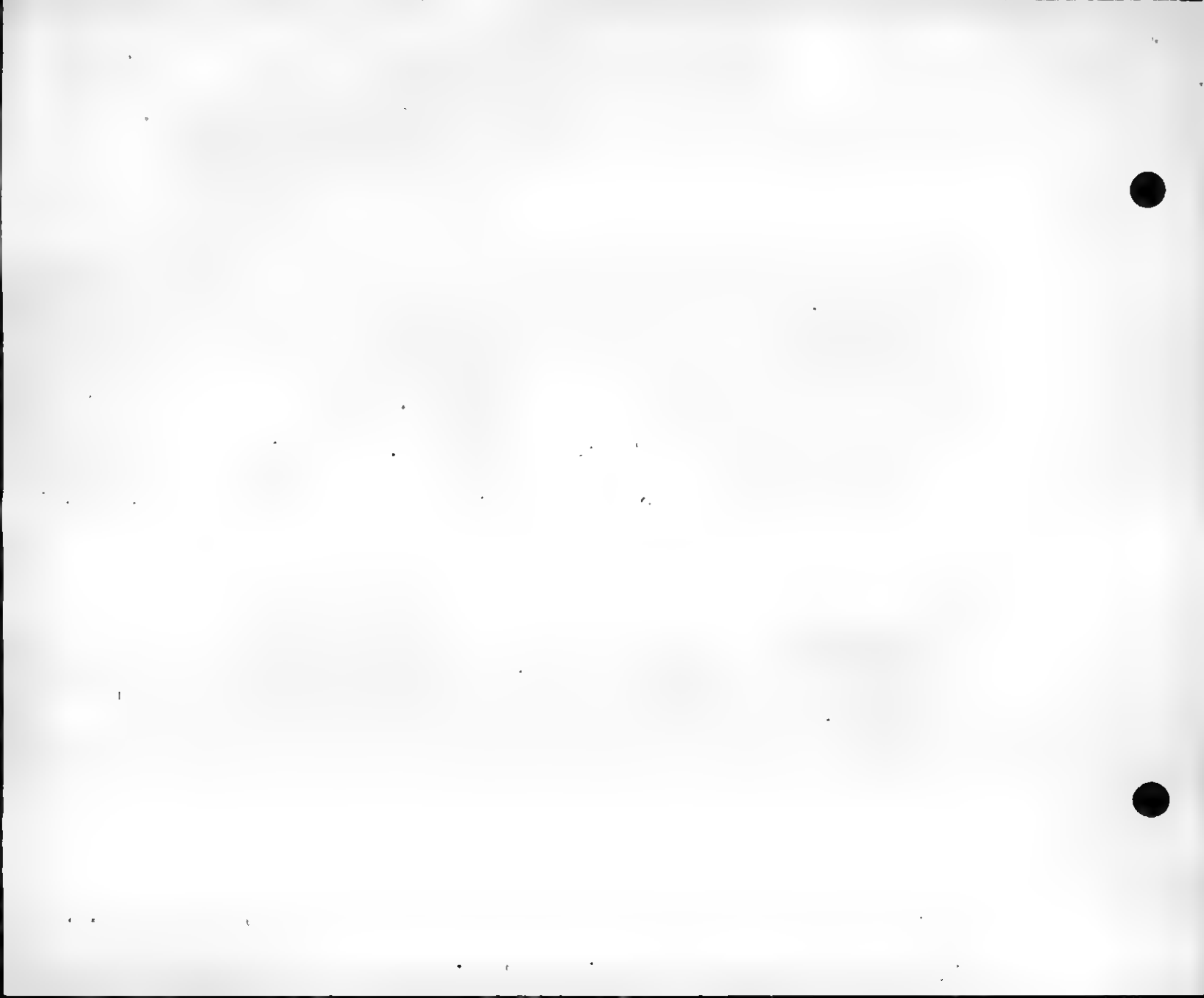
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10500

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10493

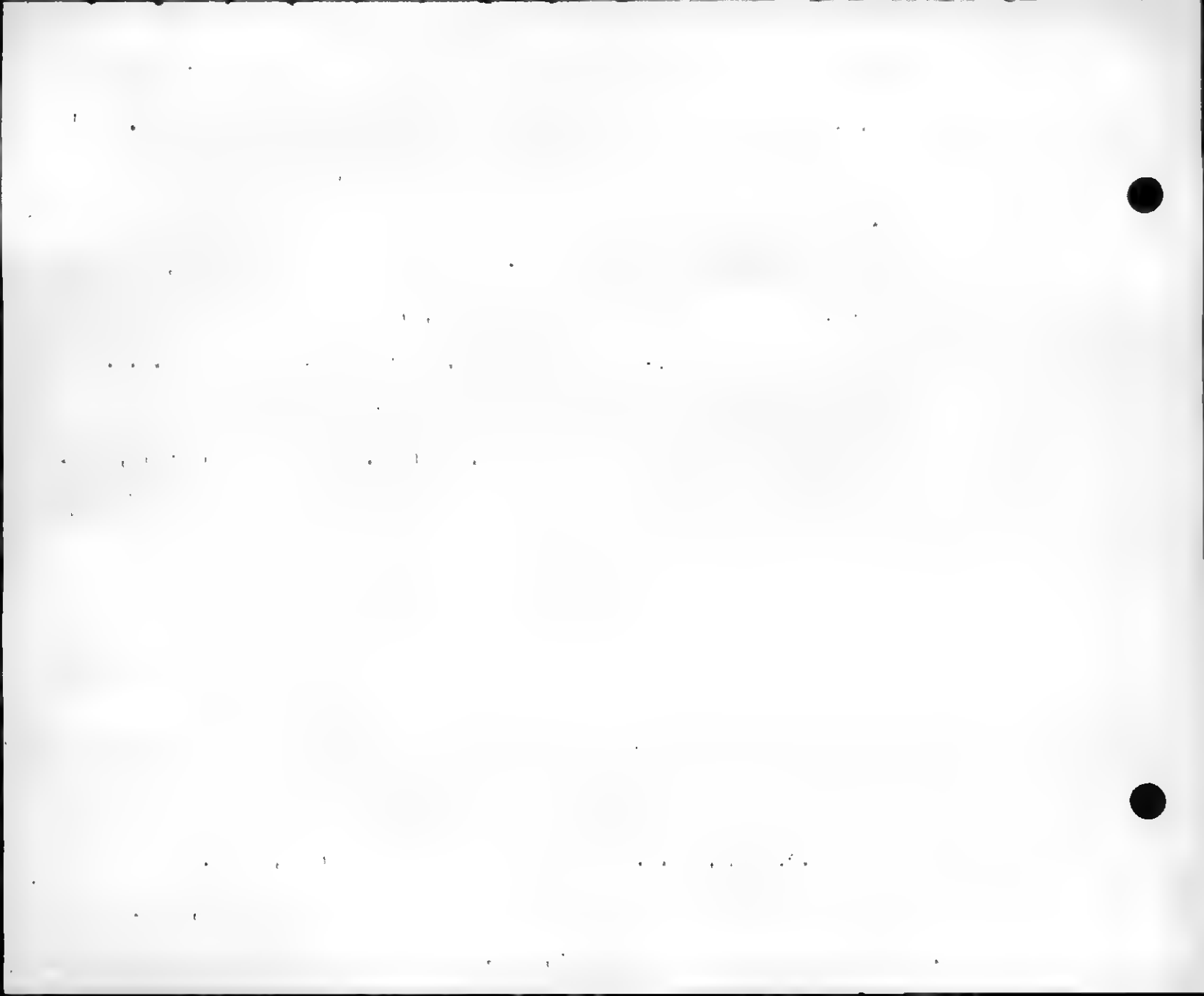
1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dameron</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>U. S. Naval Air Station,</u>			
c. LENGTH OF STAY IN ID <u>1 month</u>				d. STREET ADDRESS <u>Patuxent River, Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Station Hospital, NAS, Patuxent River</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Stewart TAYLOR</u>				4. DATE OF DEATH Month Day Year <u>July 13 19 66</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11 DEC 1947</u>	
9. AGE (in years last birthday) <u>18</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Kearny, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Airman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>			
13. FATHER'S NAME <u>Henry A. TAYLOR (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Mima B. TAYLOR</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes JUN 65-JUL 66</u>				16. SOCIAL SECURITY NO. <u>146-4009-06</u>			
17. INFORMANT <u>Enlisted Personnel Record</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Injuries</u> 8164 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Auto Accident</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in parked car, that was struck by an oncoming vehicle.</u>			
20c. TIME OF INJURY Month, Day, Year <u>10:30 p.m. July 13, 66</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>				20f. (City or town) <u>St. Mary's</u> (State) <u>Dameron, Maryland</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R. E. BURNEISTER</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. E. BURNEISTER, LT MC USN</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <u>NAS PAX RIV MD</u>				22. DATE SIGNED <u>14 JUL 66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>7/18/66</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>HAZLET, N.J.</u>				23d. LOCATION (City, town or county) (State) <u>N.J.</u>			
24. FUNERAL DIRECTOR <u>W. CLARKE MATTINGLEY</u>				ADDRESS <u>LEONARDTOWN, MD.</u>			
25a. REC'D BY REGISTRAR <u>JUL 18 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
16501					10494									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY ST. MARY'S					a. STATE MARYLAND									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					b. COUNTY ST. MARY'S									
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)									
LEONARDTOWN					12 DAYS									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS									
ST. MARY'S HOSPITAL					GREAT MILLS									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last					Month Day Year									
JAMES ROLAND TENNYSON					JULY 9, 1966									
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)						
MALE		WHITE		WIDOWED		JULY 9, 1896		70 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		IF FUNERAL 1 YEAR IF UNDER 24 HRS.						
TRUCK DRIVER		LAUNDRY		ST. MARY'S MARYLAND		U.S.A.		Months Days Hours Min.						
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
GEORGE H. TENNYSON					DOSHIE WILLIAMS									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address				
No										MRS. MARIE T. CLARKE CALIFORNIA, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of esophagus DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 3 years				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
19														
21. I certify that (I) (this hospital) attended the deceased from March , 1964, to July 9 , 1966, that (I) (we) last saw the deceased alive on July 9 , 1966, and that death occurred at 10 P M, from the causes and on the date stated above.														
22a. SIGNATURE										22b. DATE SIGNED				
P.J. BEAN, M.D.										July 10/66				
22c. PHYSICIAN'S NAME (Typed)										22d. ADDRESS				
P.J. BEAN, M.D.										GREAT MILLS, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)					
BURIAL			7/12/66			HOLY FACE			GREAT MILLS, Md.					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
W. CLARKE MATTINGLEY LEONARDTOWN, Md.						JUL 14 1966			notary Judge					



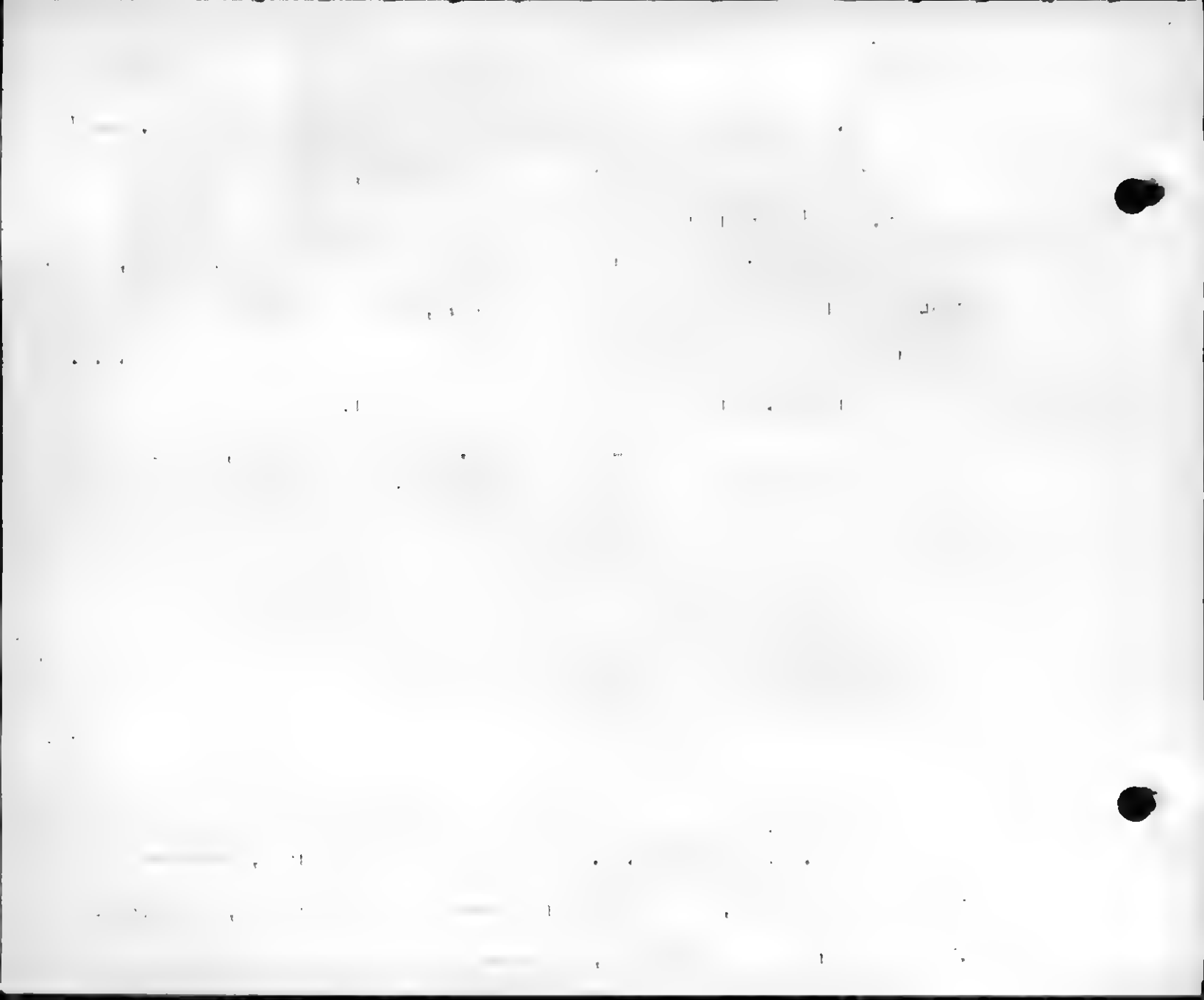
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10502 CERTIFICATE OF DEATH 11495

1. PLACE OF DEATH a. COUNTY ST. MARY'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BUSHWOOD d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERTA Middle WRIGHT Last TURNER		4. DATE OF DEATH Month JULY Day 12 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 5, 1898
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR: Months 8 Days 6 Hours 8 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POSTMISTRESS		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ADDISON T. WRIGHT		14. MOTHER'S MAIDEN NAME SADIE EAST	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 577-03-5198	
17. INFORMANT ROY E. TURNER		Address BUSHWOOD, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 18 hrs	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1960 to 7/12, 1966 , that (I) (we) last saw the deceased alive on 7/12, 1966 , and that death occurred at M , from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE J. Roy Guyther		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. ROY GUYTHER M. D.		22d. ADDRESS MECHANICSVILLE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 15, 1966	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City, town or county) (State) SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR JUL 18 1966	
ADDRESS LEONARDTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE W. Clarke Matingley	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10503

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

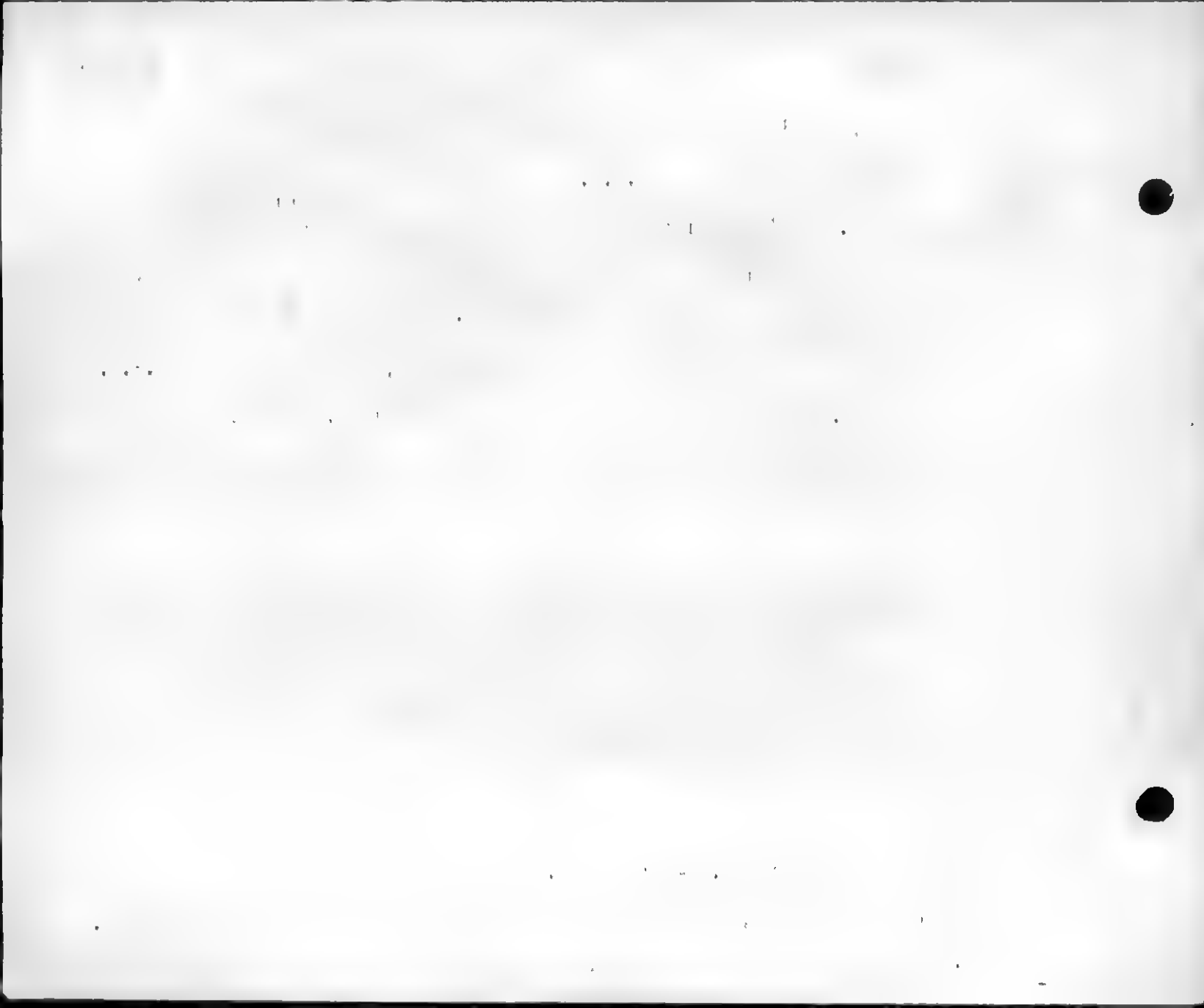
10496

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY ST. MARY'S MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MASSACHUSETTS b. COUNTY <input checked="" type="checkbox"/>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c LENGTH OF STAY IN 1b D.O.A.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S HOSPITAL		d STREET ADDRESS BROOKLINE STREET # 4 EAST BROOKLYN STREET	
3 NAME OF DECEASED (Type or print) First Middle Last LONNIE ANDREW WELLS		4 DATE OF DEATH Month Day Year JULY 2, 1966	
5 SEX MALE	6 COLOR OR RACE NEGRO	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH AUG. 22, 1957
9 AGE (In years last birthday) yrs 10 8		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) NEW PORT, RHODE ISLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OSCAR A. WELLS		14. MOTHER'S MAIDEN NAME GLORIA A. CAMPBELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT MOTHER		Address SAME AS # 2 ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DROWNING - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 30 min.
20a EXTERNAL CAUSE WAS PRIMARY CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell in open SEWAGE LAUNCH	
20c TIME OF INJURY Month, Day Year Hour 6:00 pm 7-2-1966	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W.H. Patrick EXAMINER'S NAME (Type) WILLIAM H. PATRICK M. D.		22. DATE SIGNED 7-3-66	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF JULY 8, 1966	23c NAME OF CEMETERY OR CREMATORY MT HOPE CEMETERY	23d LOCATION (City or Town) (County) (State) BOSTON, MASS.
24 FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25a REC'D BY REGISTRAR DATE JUL 7 1966	25b REGISTRAR'S SIGNATURE Charles Judge



1
FOR STATE
HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10504

10497

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Wisconsin</u> COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patuxent River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NAS, Patuxent River / Palmyra</u>	
c. LENGTH OF STAY IN 1b <u>3 years</u>		d. STREET ADDRESS <u>Service / Test / P.O. Box 237</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Station Hospital, NAS, PAX RIV MD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Clifford</u> Last <u>WHITBECK</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9 June 1944</u>
9. AGE (In years last birthday) <u>22</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ADJ3</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Alvin WHITBECK</u>		14. MOTHER'S MAIDEN NAME <u>Veronica Marie FOX (Deceased)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>388 40 8372</u>	
17. INFORMANT <u>1962 - 1966</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra-cranial Injuries</u> 8254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Automobile Accident</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in POV involved in accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4:00</u> <u>3:00</u> p.m. <u>July 7 19 66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road</u>		20f. (City or town) (County) <u>Md.</u> (State) <u>Patuxent River, St. Mary's</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>C. F. MAC CARTHY, LT MC USNR</u>		22. DATE SIGNED <u>7 July 1966</u>	
EXAMINER'S NAME (Type) <u>Charles Judge</u>		Address (Street, city, town, or county) <u>NAS PAX RIV MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JULY 12, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u> </u>		23d. LOCATION (City, town or county) (State) <u>PALMYRA, JEFFERSON, WISCONSIN</u>	
24. FUNERAL DIRECTOR <u>W. CLARKE MATTINGLEY</u>		ADDRESS <u>LEONARDTOWN, MARYLAND</u>	
25a. REC'D BY REGISTRAR <u>JUL 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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[The remainder of the page contains extremely faint, illegible text and markings.]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10505

CERTIFICATE OF DEATH

10498

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - GREAT MILLS 18-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARYS NURSING HOME				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LEOLA Middle MARY Last WISE				4. DATE OF DEATH Month JULY Day 14 Year 19 66			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/1888		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE W. GRAVES				14. MOTHER'S MAIDEN NAME MARTHA ANN SHADE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 215 07 3248		17. INFORMANT Address MRS. AGNES BEAN - LEXINGTON PARK, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac fibrillation 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 hour 3 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 3, 1966 , to July 14, 1966 , that (I) (we) last saw the deceased alive on July 13, 1966 , and that death occurred at 2 A M, from causes on and on the date stated above.							
22a. SIGNATURE P.J. BEAN				22b. DATE SIGNED 7/15/66		22c. PHYSICIAN'S NAME (Type) P.J. BEAN	
22d. ADDRESS GREAT MILLS, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/16/66		23c. NAME OF CEMETERY OR CREMATORY HOLY FACE CEMETERY		23d. LOCATION (City or Town) (County) (State) GREAT MILLS, MARYLAND	
24. FUNERAL DIRECTOR JOHN M. WELCH - LEONARDTOWN, MARYLAND				25a. REC'D BY REGISTRAR DATE JUL 18 1966		25b. REGISTRAR'S SIGNATURE <i>John M. Welch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

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